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AFFIDAVIT OF SURVIVORSHIP

I, Dorothy Woods, being duly sworn, do hereby depose and attest that:

The Decedent, Roosevelt Woods, is named in the attached death certificate.

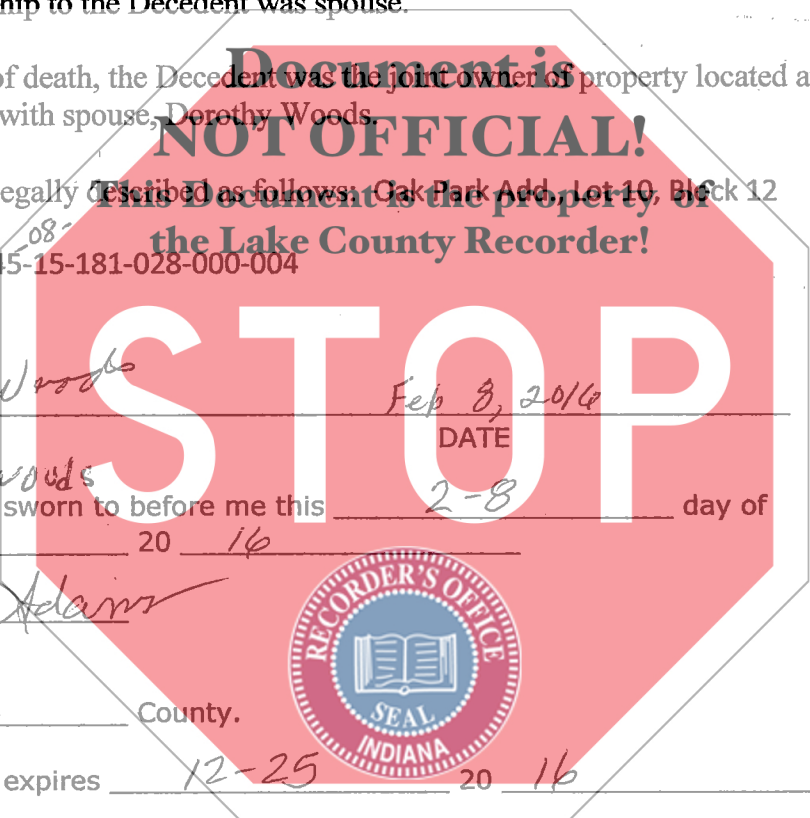
The Decedent died on August 25, 2004 and was legally married at the time.

The name of the Decedent's survivor is Dorothy Woods.

My relationship to the Decedent was spouse.

At the time of death, the Decedent was the joint owner of property located at 2436 Virginia Street along with spouse, Dorothy Woods.

The property is legally described as follows: Oak Park Add., Lot 10, Block 12 Parcel Number 45-15-181-028-000-004



2016 015280

MICHAEL B. BROWN
RECORDER

2016 MAR 15 AM 11:12

STATE OF INDIANA
LAKE COUNTY
FILED FOR RECORD

Dorothy Woods
AFFIANT

Feb 8, 2016
DATE

Dorothy Woods

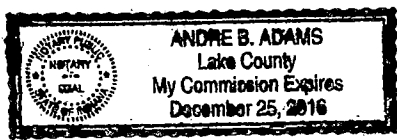
Subscribed and sworn to before me this 2-8 day of Feb 2016

Andre B Adams
(Notary Public),

Lake County.



My commission expires 12-25 2016



FILED

MAR 15 2016

"I AFFIRM, UNDER THE PENALTIES FOR PERJURY, THAT I HAVE TAKEN REASONABLE CARE TO REDACT EACH SOCIAL SECURITY NUMBER IN THIS DOCUMENT, UNLESS REQUIRED BY LAW."
PREPARED BY: G.T.

JOHN E. PETALAS
LAKE COUNTY AUDITOR

AMOUNT \$ 14-
CASH CHARGE _____
CHECK# _____
OVERAGE _____
COPY _____
NON-CONF _____
DEPUTY NR

011678

ATTENTION: This Social Security # is being requested by this state agency in order to pursue its statutory responsibility. Disclosure is voluntary and there will be no penalty for refusal.

INDIANA STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

State No.

Local No. 04 0527

THE RECORDS IN THIS SERIES ARE CONFIDENTIAL PER IC 16-37-1-10

TYPE/PRINT
IN
PERMANENT
BLACK INK

DECEDENT

PARENTS

INFORMANT

DISPOSITION

CAUSE OF DEATH

CERTIFIER

HEALTH OFFICER

1. DECEASED—NAME (First, Middle, Last) Roosevelt Woods		2. SEX Male	3a. TIME OF DEATH 3:20 P M	3b. DATE OF DEATH (Month, Day, Year) August 25, 2004
4. SOCIAL SECURITY NUMBER [REDACTED]	5a. AGE—Last Birthday (Years) 76	5b. UNDER 1 YEAR Months: Days:	5c. UNDER 1 DAY Hours: Minutes:	6. DATE OF BIRTH (Mo, Day, Yr) April 27, 1928
7. BIRTHPLACE (City and State or Foreign Country) Helena, Arkansas	8a. WAS DECEDENT A U.S. VETERAN? NO			
8b. YEAR LAST SERVED IN U.S. ARMED FORCES? N/A		9a. PLACE OF DEATH (Check only one. See instructions) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Residence		
9b. FACILITY NAME (If not institution, give street and number) 2436 Virginia Street		9c. CITY, TOWN OR LOCATION OF DEATH Gary	9d. COUNTY OF DEATH Lake	
10. MARITAL STATUS (Specify) Married	11. SURVIVING SPOUSE (If wife, give maiden name) Dorothy M Sykes	12a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired) Cement Mason		12b. KIND OF BUSINESS/INDUSTRY Local Union #406
13a. RESIDENCE—STATE Indiana	13b. COUNTY Lake	13c. CITY, TOWN OR LOCATION Gary	13d. STREET AND NUMBER 2436 Virginia Street	
13e. ZIP CODE 46407	13f. INSIDE CITY LIMITS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	14. CITIZEN OF WHAT COUNTRY? U S A	15. WAS DECEDENT OF HISPANIC ORIGIN? <input checked="" type="checkbox"/> Yes (If yes, specify Cuban, Mexican, Puerto Rican, etc.)	16. RACE—American Indian, Black, White, etc. (Specify) Black
17. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5 +)		18. FATHER'S NAME (First, Middle, Last) Rubin Woods		
19. MOTHER'S NAME (First, Middle, Maiden Surname) Willie B. Willis		20a. INFORMANT'S NAME (Type/Print) Dorothy M. Woods		
20b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2436 Virginia Street, Gary, Indiana 46407		20c. Relationship Wife		
21a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		21b. DATE AND PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) August 31, 2004 Oak Hill Cemetery		21c. LOCATION—City or Town, State Gary, Indiana
22a. EMBALMERS NAME Roosevelt Allen Jr.		22b. EMBALMER'S LICENSE NO. #01051701	23. WAS DEATH REPORTED TO CORONER? <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
24. SIGNATURE OF FUNERAL DIRECTOR <i>[Signature]</i>		24b. LICENSE NUMBER (of Licensee) #29700070	25. NAME, ADDRESS, AND LICENSE NUMBER OF FUNERAL HOME Guy & Allen Funeral Directors, Inc 2959 West 11th Avenue Gary, Indiana 46404 83007704	
26. PART I. Enter the disease, injuries, or complications that caused the death. Do not enter nonspecific terms, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Electrolyte Imbalance / Short Bowel Syndrome Approximate Interval Between Onset and Death 4 years 3 yrs 1hr Conditions, if any, which gave rise to the immediate cause, stating the underlying cause last Candida meningitis failure		PART II. Other significant conditions - Conditions contributing to death but not previously stated in Part I.		
27. WAS DECEDENT PREGNANT OR 90 DAYS POSTPARTUM? (Yes or no) NO		28a. WAS AN AUTOPSY PERFORMED? (Yes or no) NO	28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> HEALTH OFFICER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) as stated. <input type="checkbox"/> CORONER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. MEDICAL LICENSE NO. 01054231A
29d. DATE SIGNED (Month, Day, Year) September 1, 2004		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 26) (Type/Print) Dr. Ibekie 1217 U S Highway 41 Schererville, Indiana 46375		
31. HEALTH OFFICER'S SIGNATURE <i>[Signature]</i>		32. DATE FILED (Month, Day, Year) SEP 07 2004		
33. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		34a. DATE OF INJURY (Month, Day, Year)	34b. TIME OF INJURY	34c. INJURY AT WORK? (Yes or no)
34d. DESCRIBE HOW INJURY OCCURRED		34e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. (Specify)		34f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
34g. DATE PRONOUNCED DEAD (Month, Day, Year)		34h. MOTOR VEHICLE ACCIDENT? (Yes or no) If yes, specify driver, passenger, pedestrian, etc.		